TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Copley Hospital Inc

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-16-0326-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I would like to have this bill reviewed and considered to be paid close to the State of VT fee guidelines of 83% for Workman's Compensation. Or as stated in the State of Texas Hospital Fee Guidelines, Subchapter E Health Facility Fees, 28 TAC §§134.403 and 134.404, under the Federal Medicare Rates."

Amount in Dispute: $38,765.34

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the requestor has not produced any evidence that Texas Mutual's payment did not meet its cost to provide the treatment. Absent such no additional payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 4-5, 2015	Critical Access Services	$38,765.34	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, reimbursement guidelines for medical services provided in an outpatient acute care hospital on or after March 1, 2008.
3. 28 Texas Administrative Code §134.1 effective March 1, 2008, 33 *Texas Register* 626, sets forth general provisions related to medical reimbursement.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s)
   - 225 – The submitted documentation does not support the service being billed
   - 895 – 133.210 requires itemized statement for hospital services
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - 193 – Original payment decision is being maintained
   - 370 – This hospital outpatient allowance was calculated according to the APC rate, plus a markup
   - 420 – Supplemental payment
   - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
   - 891 – No additional payment after reconsideration

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Is the requestor classified as a Critical Access Hospital (CAH)?
3. What is Medicare's reimbursement policy for CAH?
4. What is the DWC reimbursement methodology applicable to this dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The requestor provided services in the state of Vermont, June 4 - 5, 2015 to an injured employee with an existing Texas Workers' Compensation claim. The request was dissatisfied with the respondent's final action. The requestor file for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The Division concludes the because the requestor sought the administrative remedy outline in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.

2. According to CMS NPI Registry, https://nppes.cms.hhs.gov, Copley Hospital, Inc, located in Morrisville, VT is classified as a Critical Access Hospital.

3. Pursuant to 28 Texas Administrative Code §134.403(d), "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date of service is provided with any additions or exceptions specific in this section."

   28 Texas Administrative Code §134.404(f) states, "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register."

   Per the Centers for Medicare & Medicaid Services, Critical Access Hospital, ICN 006400 September 2014, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/critaccesshospfctsht.pdf "CAH Payments - CAHs are paid for most inpatient and outpatient services to Medicare patients at 101 percent of reasonable costs. CAHs are not subject to the Inpatient Prospective Payment System (IPPS) or the Hospital Outpatient Prospective Payment System (OPPS)."

4. Pursuant to 28 Texas Administrative Code §134.403(e)(1-3) which states,
   Regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code 413.011; or
(2) if no contracted fee schedule exists that complies with Labor Code 413.011, the maximum allowable reimbursement (MAR) amount under subsection (f), including any applicable outlier payment amounts and reimbursement for implantables;
(3) If no contracted fee schedule exists that complies with Labor Code 413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with 134.1 of this title (relating to Medical Reimbursement).

Review of the submitted documentation finds the provisions of Rule 134.403 (1) and (2) do not apply therefore; the disputed services shall be determined in accordance with 28 Texas Administrative Code §134.1.

5. 28 Texas Administrative Code §134.1(f) (1-3) states,

Fair and reasonable reimbursement shall:

(1) be consistent with the criteria of Labor Code §413.011;
(2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
(3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O) requires the provider to submit with the request for dispute resolution, "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable."

Review of the submitted documentation finds that:

- The requestor's position statement asserts that "I would like to have this bill reviewed and considered to be paid closed to the State of VT fee guidelines of 83% for Workman's Compensation. Or as stated in the State of Texas Hospital Fee Guidelines, Subchapter E. Health Facility Fee, 28 TAC §§134.403 and 134.404, under the Federal Medicare Rates." This statement is insufficient to support how the additional payment would achieve effective medical cost control.
- The requestor does not discuss or explain how the amount sought is a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November 3, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.